STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676314	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capstone Healthcare Estates on Orem	3730 W. Orem Drive Houston, TX 77045

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27846 Based on interviews and record review, the facility failed to ensure residents were free from significant medication errors for 1 of 24 residents (Resident #51) reviewed for significant medication errors. The facility failed to ensure Metoprolol (a blood pressure (BP) medication given to lower high blood pressure) was administered six times in March 2025 to Resident #51 as ordered on 02/26/2025 by the physician and Resident #51 was administered Metoprolol 12.5 mg outside of physician set parameter of the residents SBP (the top BP number) less than 100 hold. This failure could place residents at risk of not receiving desired therapeutic outcomes, increased side effects, or a decline in health. Findings included: Record review of Resident #51's admission face sheet, undated, reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included: Atrial Fibrillation (irregular often rapid heart rate resulted in poor blood flow), Hypertension (high blood pressure), cardiac pacemaker (small Implanted electronic device to help the hearts rhythm with electric impulses). Record review of Resident #51's quarterly Minimum Data Set (MDS) dated [DATE] reflected the resident's Brief Interview for Mental Status (BIMS (a score used to assess cognitive function) was 15 which indicted his cognition was intact. The MDS indicated Resident #51's speech was clear. He was able to make himself understood and he was able to understand others. The resident required supervision only for eating and oral hygiene. He required maximum assistance for toileting, showers/baths. Partial assistance was needed for personal hygiene. Resident #51 was always frequently incontinent of bowel and bladder. Record review of Resident #51's care plan initiated 02/24/2025 reflected the following: Problem: The resident received hypertensive medications. Goal: The resident would receive hypertensive medications without any complications. Interventions: Provide Metoprolol as ordered (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff would check blood pressure before medications were given. Record review of Resident #51's order summary report, active orders dated as of 04/03/2025, revealed, Metoprolol Tartrate Tablet. Give 12.5 mg by mouth two times a day related to hypertension. Hold for a systolic blood pressure (SBP) less than 100. Order dated 02/26/2025. Record review of Resident #51's March 2025 Medication Administration Record (MAR) dated 03/01/2025 -03/31/2025 reflected, the resident was administered Metoprolol 12.5 mg outside of physician set parameter of SBP (The top BP reading) less than 100 on: 03/02/2025 at 9:00AM with BP 88/61 by MA A 03/03/2025 at 9:00AM with BP 97/64 by MA A 03/04/2025 at 5:00 PM with BP 95/60 by MA B 03/05/2025 at 5:00 PM with BP 97/62 by MA B 03/09/2025 at 9:00 AM with BP 97/65 by MA A 03/20/2025 at 9:00 AM with BP 90/61 by MA A In an interview and record review of Resident #51's MAR on 04/02/2025 at 10:10 AM MA A stated the initials documented on 03/02/2025, 03/03/2025, 03/09/2025, 03/20/2025 were her initials. The MA A stated the check mark documented the medication was given. MA A stated when the blood pressure was outside the ordered parameters it should not have been given. MA A stated if a medication was not administered it would be documented it was not given due to outside parameters. MA A stated the medication should not have been given on the dates. MA A stated she knew better than to give it. She stated it must have been incorrect documentation. MA A stated the pharmacist trained the staff on medication administration which included observed administration of medications. To prevent this again she would slow down, read the order and document correctly. In a phone interview on 04/02/2025 at 11:24 AM the facility pharmacist stated the physician ordered parameter was to help hold the resident's BP above a certain level. It was to prevent the BP from dropping too low. The pharmacist stated the expectation was the physician's hold order was followed. The risk was the BP could go too low. The pharmacist stated she did routine staff in-service and monitored medication administration. In a phone interview on 04/02/2025 at 12:40 PM Resident #51's NP stated she saw the resident's BP ran low. She stated the reason for the parameter hold order was a guide to keep the resident's BP at a safe level. The NP stated the medication was to lower BP. The risk was the BP would drop too low. The NP stated Resident #51's BP did run low. The NP continued and stated the resident needed the medication for his heart. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a phone interview on 04/02/2025 at 12:58 PM MA B stated she checked the BP. MA B stated she checked the parameter to make sure it was alright to give. The MA stated the parameter was to hold for the resident's SBP less than 100 the medication should not have been given. The Medication was to lower the BP. The risk was the BP would go too low. Next time she would double check before she gave any medication. In an interview on 04/03/2025 at 9:13 AM ADON stated the risk of the medication administered under the ordered parameter was low BP, fainting, hospitalization . The ADON stated the pharmacist regularly in-serviced the staff on medication administration. The ADON stated the MARs were reviewed daily in the morning meeting to monitor administration of medications. The ADON stated regular monitoring included administration, omission and availability of medications. In an interview on 04/03/2025 at 11:39 AM DON stated the risk of the medication being administered below the ordered hold value was the BP dropping. The DON stated she did not know why it was administered to Resident #51. The DON stated she thought it may have been a documentation error. The DON stated reeducation for following the physician's orders would be done to prevent this again. In an interview on 04/03/2025 at 2:45 PM the Administrator stated he understood a resident received a BP medication when the BP was under the ordered hold parameter. He stated he was not clinical, and he did not know all the risks and effects. The Administrator stated he expected medication to be administered as ordered without medication errors. In a follow up interview on 04/03/2025 at 3:11 pm The DON stated medication administration was monitored daily during the stand-up morning meetings the MARs were reviewed. Record review of the facility policy titled Administering Medications Revised dated April 2019 read in part . Policy Statement Medication are administered in a safe and timely manner, .and as prescribed. Policy Interpretation and Implementation 4. Medications are administered in accordance with prescribed orders, including any time frame .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27846 Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 24 residents (Resident #40) reviewed for infection control practices. The facility failed to ensure CNA C followed proper infection control, glove changes and hand hygiene for Resident #40 during incontinent care. CNA C failed to use a clean wipe, change gloves and perform hand hygiene during incontinent care. This failure could place residents at risk of infection or a decline in health. The findings included: Record review of Resident #40's admission face sheet undated revealed a [AGE] year-old male originally admitted to the facility on [DATE]. Resident #40 was readmitted on [DATE]. Resident #40's diagnoses included: hemiplegia /hemiparesis (muscles weakness or partial paralysis to one side of the body), diabetes mellitus (body did not produce enough insulin or use it properly), nontraumatic intracerebral hemorrhage (bleeding within the brain not caused by an injury), epilepsy (nerve cell activity in the brain was not working correctly resulted in seizures), Cerebrovascular disease (condition affected the brain's blood vessels and blood flow). Record review of Resident #40's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #40's speech clarity identified he had no speech. Resident #40 rarely/never made himself understood. The resident rarely/never understood others. Brief Interview for Mental Status (BIMS (a score used to assess cognitive function) was unable to be scored. Resident #40's cognitive skills for daily decision making was moderately impaired. Continued review of the MDS revealed Resident #40 was dependent on staff for eating, oral hygiene, toileting hygiene shower/bathe, personal hygiene. Resident# 40 was always incontinent of his bowel and bladder. Record review of Resident # 40's care plan updated on 02/14/2025 revealed: Problem: Resident was incontinent of bowel and bladder related to stoke, hemiplegia. Goal: The resident would remain free from skin breakdown due to incontinence. Interventions: Clean perineum (area of skin between anus and scrotum) with each incontinent episode. Record review of Resident #40's order summary report dated 04/03/2025 revealed Zinc oxide ointment 10% apply to scrotum two times a day for skin condition. Order dated 12/07/2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/03/2025 at 9:28 AM during incontinent care revealed Resident #40 in bed on his back with the head of the bed elevated. Resident #40 was nonverbal. CNA C was positioned on the left side of the resident's bed. CNA D was positioned on the right side of the resident's bed. Resident #40 was turned to his right side. The resident's brief was rolled under the resident. CNA C used one incontinent wipe cleaned down the resident's right buttock, cleaned down the resident's left buttock, and cleaned the resident's anal area. Continued observation revealed Resident #40 was positioned on his back. Without a glove change or hand hygiene, CNA C obtained one new wipe. CNA C wiped down the resident's right groin, down the residents left groin, down his penis with the same wipe. In an interview on 04/03/2025 at 9:43 AM CNA C stated she did clean the resident's back first before she moved to the front. CNA C stated the resident should have been cleaned from front to back. CNA C stated she did use the same wipe to clean. She did not get a new wipe each time. CNA C stated gloves were to be changed and hand hygiene should have been done. CNA C stated she started with his buttock because he was on his side already. CNA C stated she was nervous. CNA C stated she was not thinking that was why she did not change the wipes, her gloves or do hand hygiene. CNA C stated the risk was an infection. The CNA stated she would slow down to prevent this again. In an interview on 04/03/2025 at 11:04 AM CNA D stated each wipe should have been discarded after one wipe and not reused. CNA D stated the resident's front should have been cleaned before the back. The CNA should have changed her gloves and washed her hands. CNA D stated she did not know why this occurred. She stated the risk was infection because of contamination. In an interview on 04/03/2025 at 11:39 AM the DON stated the staff reported to her the incontinent care was not done correctly. The DON stated CNA C was reminded the disposable wipes should be discarded after one use. The CNA was reminded when she cleaned from one area to another, gloves were to be changed. Hand hygiene was to be done with glove changes and care was to be done from front to back. The resident's care should not have started at the buttocks. The DON stated this was an experience CNA. The DON stated she did not know why this happened. The DON stated she expected proper infection control to be followed. The DON stated the risk was infection and to prevent this again the staff would be retrained. In an interview on 04/03/2025 at 2:45 PM the Administrator stated he was notified proper procedure was not followed during the resident's care. The Administrator stated he expected infection control protocols were followed to prevent infection. He stated the risk was infection. The Administrator stated to prevent this again the staff would be reeducated on infection control. In a follow up interview on 04/03/2025 at 3:11 PM the DON stated we monitored infections during the morning stand up meetings. The DON stated trainings were done annually and as needed during the year. Record review of the facility policy titled Perineal Care Revised dated February 2018 read in part . Purpose The purpose of this procedure are to provide cleanliness and comfort to the resident, to prevent infection an skin irritation and to observe the resident's skin condition . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy titled .Infection Control Revised dated October 2018 read in part . Policy Statement this facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of disease and infections .Policy Interpretation and Implementation 2. The objectives of our infection control policies and practices are to: a. Prevent, detect, investigate, and control infections in the facility; b. Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors and the general public .